

MENTAL HEALTH AND DISABILITY SERVICES COMMISSION
February 28, 2013, 9:30 am to 3:00 pm
Pleasant Hill Public Library
5151 Maple Drive, Pleasant Hill, Iowa
MEETING MINUTES

MHDS COMMISSION MEMBERS PRESENT:

Lynn Crannell	Zvia McCormick
Richard Crouch	Laurel Phipps
Jill Davisson	Patrick Schmitz
Richard Heitmann (by phone)	Susan Koch-Seehase
Chris Hoffman (by phone)	Dale Todd (by phone)
David Hudson (by phone)	Suzanne Watson
Gary Lippe	Jack Willey

MHDS COMMISSION MEMBERS ABSENT:

Neil Broderick	Representative Lisa Heddens
Senator Joni Ernst	Lynn Grobe
Senator Jack Hatch	Deb Schildroth
Representative Dave Heaton	Gano Whetstone

OTHER ATTENDEES:

Theresa Armstrong	MHDS, Bureau Chief, Community Serv. & Planning
Robert Bacon (by phone)	U of Iowa Center for Disabilities and Development
Dave Basler	ChildServe
Teresa Bomhoff	Iowa Mental Health Planning Council/NAMI
Lynsie Crawford	DSCI, Iowa Department of Human Rights
Eileen Creager	Aging Resources of Central Iowa
Diane Diamond	DHS, Targeted Case Management
Marissa Eyanson	Easter Seals
Connie Fanselow	MHDS, Community Services & Planning
Melissa Havig	Magellan Health Services
Julie Jetter (by phone)	MHDS, Community Services & Planning
Todd Lange (by phone)	Office of Consumer Affairs
Brad Leckrone	County Social Services
Marcy Murphy	SE Iowa Case Management
Todd Noack	Office of Consumer Affairs
Jim Paprocki (by phone)	Office of Consumer Affairs
Renee Schulte	DHS Consultant
Rick Shults	DHS, Administrator MHDS Division
Deb Eckerman Slack	ISAC County Case Management Services
Robyn Wilson	MHDS, Community Services & Planning
Ann Wood (by phone)	Office of Consumer Affairs

WELCOME AND CALL TO ORDER

Jack Willey called the Commission business meeting to order at 9:35 a.m. and led introductions. Quorum was established. No conflicts of interest were declared.

APPROVAL OF MINUTES

Jill Davisson made a motion to approve the January 17, 2013 meeting minutes as presented. Richard Crouch seconded the motion. The motion passed unanimously.

COUNTY SOCIAL SERVICES MANAGEMENT PLAN

Brad Leckrone, representing County Social Services (CSS) referenced the section on "Resource Management" on page 48 of their revised management plan. He noted that the revised language still indicates that case managers will review standardized assessment tools, but the references to specific assessment tools have been removed because the decisions have not all been finalized yet. CSS is currently using the SIS (Supports Intensity Scale) for people with intellectual disabilities and the LOCUS (Level of Care Utilization System) for people with mental illness; they are also reviewing the Mayo Portland for use with people who have brain injuries.

Patrick Schmitz said there were some concerns at the last meeting about whether there were differences between individuals with a mental health issue and those in other disability groups, and also some concerns about the plan or process for appealing a decision and getting additional advice. He said Bob did not clarify how that would be done.

Brad read the proposed new language:

Service Coordinators will ensure that individuals are receiving the optimal level/site of care for their assessed needs and that this is reimbursable under the Plan. Services for individuals with mental health needs must be medically necessary as defined by IAC 441-79.9(2).

The Resource Management Program will use national recognized evidence based standardized assessment tools to assign individuals to one of six levels of care. Each level of care has a progressively intense array of service interventions to address individual behavioral health needs. (Appendix Level of Care Determination Grid)

<i>The level of care determination does not fix or cap services entitled to an individual.</i>
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The Service Coordinator will look at service plans, review level of functioning, social history and clinical assessment (psychological testing or psychiatric evaluation or History and Physical) and may also complete, or request that the Case Manager complete, a standardized assessment tool.

If warranted the Service Coordinator may conduct a peer review with the assigned Medicaid Case Manager or Service Coordinator.

Service Coordinators will conduct resource management in a supportive manner to enhance the quality of care and build consensus. Objective tools and analysis will be included in the review. The Service Coordinator Reviewer and Case Manager must agree to any service changes. A qualified licensed professional may be used by the parties for additional clinical input.

Language was added stating that a qualified licensed professional could be used to provide additional clinical input in the review a service decision. Zvia McCormick asked if the individual receiving services could make that request. He responded that the individual client is a part of the team and that if any team member requests the consultation the region will pay for it. He added that the individual could also use the appeal process, which is attached to all notices of decision that are sent out, and if they feel there is a need for clinical input it could be addressed there. The appeal process includes three steps:

- Step 1 – An appeal is filed in writing to the administrator within 15 days of the decision, which may be done by the individual or a representative;
- Step 2 – A meeting is scheduled within 10 days to discuss the issue with the administrator; a mediator may be requested
- Step 3 – A prehearing conference is held and the matter may go to hearing before a Department of Inspections and Appeals administrative law judge or other neutral decision-maker who will issue a final written decision; individuals are provided with information on resources they can contact for legal support

Jack Willey commented that he was uncomfortable with taking action because the Commission members did not have time prior to the meeting to review the new documents. Gary Lippe asked if there was any adverse impact to the counties of delaying action. Brad responded that he did not think it would be problematic to the counties if the Commission chose to delay action. Julie Jetter noted that there are two issues before the Commission: one is to incorporate the new CSS counties into the existing plan, and the other is to approve the revisions to the plan.

The counties, as discussed at last month's meeting, that are requesting to change to the CSS plan are: Chickasaw, Fayette, Grundy, Hancock, Howard, Humboldt, Kossuth, Pocahontas, Tama, Webster, Winnebago, Worth, and Wright. All thirteen counties have voted to accept the CSS Management Plan as their county plan.

Motion: Garry Lippe made a motion to approve adding the new counties to the existing approved CSS Management Plan. The motion did not receive a second.

Patrick Schmitz said he did not believe it was presented clearly to the Commission that this was a two-step approval process and that he did not see clear information on what the impact to consumers in the joining counties would be. Julie Jetter clarified that the information on the restrictiveness of the proposed changes was provided on a one-page handout at the January meeting. Brad Leckrone said there are no real changes in what services are covered or to what level. The revisions are the removal of the language that specifically named the assessment tools and the addition of the language that allows a second opinion at county expense. He added that he thinks those are changes that are less restrictive because access to a second opinion is an expansion of services

and the use of a comprehensive assessment tool is empowering because it is strength based, not just a measure of deficits.

Motion: Jill Davisson made a motion to table action on approval of the plan changes until the next meeting, with the agenda reflecting the two items for vote: (1) approval of the 13 counties changing to the CSS Plan, and (2) approval of the proposed CSS Plan changes, and contingent on the Commission members receiving a summary of the issues in writing in time to thoroughly review prior to the meeting. Gary Lippe seconded the motion. Gary commented that he seconded the motion because the Commission seems to be at a standstill, but he does not agree that they could not go ahead with a vote today.

Vote: Chris Hoffman and Susan Koch-Seehase abstained. The motion passed by a vote of twelve to none.

MHDS UPDATE

Theresa Armstrong gave an update on pending legislation related to mental health and disability services:

SSB 1192 contains the Judicial Workgroup recommendations that were included in the December 2012 final report from DHS:

- Moving responsibility for hiring and overseeing mental health advocates into a division within the Department of Inspections and Appeals (DIA) to give them an increased level of consistency, supervision, and support
- Creating clear qualifications and job descriptions for MH advocates
- The DIA would maintain a list of all available MH advocates for judges to assign as needed
- The use of Chapter 222 commitments for person with intellectual disabilities would be eliminated since Chp. 222 commitments are used very rarely and there would probably be some transition identified for those who are currently committed under Chp. 222
- Streamlining the application process for substance abuse and mental health commitments by using common language and the same process for both
- Requiring DHS to study creating a psychiatric bed tracking system that will make it easier to locate open beds statewide

There is a subcommittee meeting scheduled on the bill. Committee members are interested in hearing from advocates and stakeholders, and they hope to move forward quickly.

HSB 109 and SF 203 are companion bills related to a specific request by MHDS for language changes in current Iowa Code or legislation. The Senate passed it out of committee last week and the House passed it out of committee this week. They include:

- A Data Workgroup recommendation for eliminating the prescriptive requirement for a unique client identifier so that a new one can be determined

- Clarification in the subacute language passed last year to reflect the intent that that licensed psychiatrists will supervise the individual care plans of individuals, not the entire subacute facility
- A House amendment changed licensed psychiatrist to mental health professional which is now a term defined elsewhere in the Code
- A change regarding ICF/PMIs (Intermediate Care Facilities for Persons with Mental Illness) to make it clear that those facilities would have to apply and meet all the qualifications to become a subacute facility as required by DIA
- A technical adjustment for use of the 70% of Community Mental Health Services Block Grant funds designated to go to community mental health centers (CMHCs) to allow more flexibility in how that money is disbursed; the money had been going to evidence based practices and emergency services and now CMHCs often want to utilize it for staff training and services

SSB 1199 – Was drafted by LSA (Legislative Services Agency) at the request of the Fiscal Viability Study Committee to pull together the recommendations of the Redesign Workgroups.

- The bill is starting in the Senate
- It provides a clarification on community corrections funding that allows county mental health programs to pay for services to individuals who are living in the community under the direction of the Department of Corrections if funds are appropriated
- It “grandfathers” children and adults who are currently receiving MH&D services but do not fall under the new eligibility groups so that their services can continue
- It provides for equalization payments to be given to approved established regions and calls for an appropriation of \$29.8 million in equalization funds to help pay for non-Medicaid services
- Last year SF 2315 said that counties had to have a strategic plan developed by April 1st each year; this legislation would allow current plans to stay in place until the regions are formed
- Provides that transition funds must be used for people currently being serviced to continue to receive services
- Directs the MHDS Commission to study and make recommendations on ways to better coordinate substance use disorder and mental health funding and for regions to be responsible for “social detoxification” services

Patrick Schmitz asked if IDPH (the Iowa Department of Public Health) is involved in that study. Theresa responded that the legislation does not call for that, but it has been discussed.

Chris Hoffman said that the majority of detox now takes place in hospitals; it is sometimes considered a level of care in community based programs, but not used very much. He said he believes the Attorney General’s Office has sometime in the last 15 years issued an opinion that detox is considered a medical treatment, not a clinical treatment, although the boundary is sometimes blurred. He said the term “social detox”

makes him uncomfortable because it is not an identified American Society of Addictive Medicine level of care.

Theresa said the bill also includes language that addresses county payment for state bills for periods prior to fiscal year 2013. It establishes June 30, 2013 as the last date any adjustments will be made to outstanding bills. It does not address what would happen if counties do not have the money to pay what they owe the state. Jack Willey said that he understood from a recent ISAC meeting with legislators that that would be addressed, but no specifics were discussed.

SSB 1199 (continued):

- As of July 1, 2013 payment responsibility moves from the county of legal settlement to the county of residence
- Funding equal to the current State Payment Program (SPP) funding will be disbursed to counties and will “follow the person” that has been funded under SPP
- Adopting Data and Statistical Workgroup recommendations, including: development of a DHS data repository; change to the client identifier; making data available to the public on an online dashboard; yearly data reports to the Commission
- Adopting Outcome and Performance Measure recommendations, including: establishing quality of life performance measures
- Adopting Children’s Services Workgroup recommendations, including: establishing a Children’s Cabinet that would be responsible for the development of children’s services using a health home model and comprehensive system of care
 - DHS would work in cooperation with the Department of Education, the Department of Public Health, and with provider, consumer and family involvement
 - The Cabinet would provide guidance, oversight, and problem-solving as the system is being developed

There is also a proposed bill that would give counties the option of returning to their current county levy rate if it is higher than the new levy rate of \$47.28 per capita.

HF 97 and HF 161 – Adds children to the required population groups to be served by the MHDS regions, although only those children who meet the same eligibility requirements applied to the adult population

HF 160

- Has passed the house and moved to the senate
- Appropriates \$11.6 million for the Transition Fund utilizing the CHIP (Children’s Health Insurance Program) contingency funds
- Counties accessing Transition Funds would have to offer assurance that the funds will be used in a way that meets all federal match requirements

- Counties would be responsible for any federal audits and any consequences of such audits
- Counties would have to pay their unpaid Medicaid bills to the State or have a plan to pay them within a certain amount of time to be eligible
- The bill would also give the Director authority to approve a region containing non-contiguous counties

Teresa Bomhoff shared information she had compiled on some of the proposed bills:

- SF 71 and HF 83 deal with integrated care models within Medicaid, direct Medicaid expansion, and establish a state health insurance exchange
- HF 97 requires regional mental health systems to provide children's mental health care
- HF 98, HF 200, and HF 201 all address something related to counties ability to levy more the new \$47.28 per capita rate
- HF 160 appropriates \$11.6 million for transition from CHIP funds
- HF 117 authorizes \$20 million for transition from state funds
- HF 137 and SF 198 deals with restrictions on admitting people with aggressive behavior to long term care facilities
- HSB 149 and SSB 1162 would give some prescription authority to certain psychologists
- HF 198 deals with workforce issues and directs DHS to make rules for reimbursable training costs as direct costs; it has passed the House
- SF 232 is the direct care workforce bill
- SF 216 makes provisions for mental health education, providing for suicide prevention and trauma informed care training to school personnel
- SF 233 deals with public safety in schools and communities

Sequestration - Theresa Armstrong noted that it appears the Sequester at the federal level will go into effect tomorrow. Some of the funding MHDS receives will be affected by reductions; most will be about 10 percent. That will apply to the Community Mental Health Services Block Grant, the PATH (Projects in Assistance for Transition from Homelessness) Program, and the Social Services Block Grant which currently funds the State Payment Program. Also affected will be the Substance Abuse Block Grant, and Disability Rights Iowa.

Proposed Regions – Theresa shared a map of proposed regional groups, noting that regions have not been finalized and it is subject to change. Three counties have applied to be exempt from joining into regions and stand alone; they are Jefferson, Polk, and Carroll counties. To date, DHS has received letters of intent to form regions from:

- Jackson, Clinton, Scott, Cedar, and Muscatine
- Jasper, Poweshiek, Marion, and Mahaska
- Adair, Adams, Union, Clarke, and Taylor
- Sioux, Plymouth, Cherokee, and Woodbury
- Lyon, Osceola, Dickinson, Emmet, O'Brien, Clay, and Palo Alto

Some of the groups have asked for technical assistance and DHS is working with them. Jack Willey asked if it would be possible for DHS to share some the technical assistance information they are providing with the Commission and others, noting that he believes all the counties have questions and are looking for guidance since there are no administrative rules yet. Theresa responded that many of the requirements are contained in SF 2315, the legislation passed during the last session, and rules will be based on what that legislation says. Letters of intent are due to be filed with the Department by April 1.

Renee Schulte - Jack invited Renee Schulte to tell the Commission about the work she is doing with the Department. Renee noted that she no longer holds elective office and as a former legislator cannot engage in lobbying for a period of time. She said she is working with the Department as a subject expert on policy issues and moving forward on MHDS Redesign. She said she is looking at standards for accessing non-Medicaid services, standardizing definitions for services, and strategic planning for children's services, including identifying gaps and best practices for keeping children safe and supported in their communities.

Financial Issues – Rick Shults shared a handout on County Funded Non-Medicaid Mental Health and Disability Services and said he wanted to present information to help put some of the challenging financial issues counties and regions are facing into context. He identified three primary issues:

1. There is a transition year challenge in fiscal year 2013 and it is tied to the unpaid Medicaid bills that some counties still owe the State.
2. There are issues of sustainability of services into the future.
3. There are operational issues of cash flow for counties that will not be receiving levy money until into October, more than 3 months after the start of the new fiscal year.

The appropriation of \$11.8 million in CHIP contingency funds for transition is moving forward, but there will be more work to be done to address the challenge of not using federal funds to pay federal match.

It will have to be determined to what extent counties will have sufficient revenues to pay for their services. DHS has been asked to provide information and has been talking to counties since early last summer about where they are financially. The Department has gathered a lot of information about the 32 counties that applied for Transition Funds, some information about other counties through technical assistance activities, and there are a few counties that DHS has limited information about.

Rick noted that page 2 of the handout shows the number of counties that have revenues available to sustain non-Medicaid costs at current levels and those that do not, assuming the SFY 2013 county levy rate and estimated revenue from the State Payment Program without Equalization money, growth, or impact (positive or negative) for changes in residency. Under these assumptions it looks like 77 counties have sufficient revenue and 22 do not. Those 22 counties would be \$11.5 million short

assuming the current levy. Moving forward with equalization, some counties will have levy rates going up and others will have levy rates going down. Under that assumption, 79 counties would have enough money and 20 counties would not, but the amount of the shortfall would be much smaller, at \$3 million.

Work has been done on estimates of how much it will take to fund non-Medicaid services. ISAC and the Department are working on estimates from different perspectives and initially had very different numbers, but have found that was mainly due to issues with communication and clarifying where the numbers were coming from. Rick said that he sat down this morning with ISAC and key legislators to talk about the numbers. DHS is at \$134 million, and ISAC is at \$135 to 136 million, so they are now very close. That is one of the key conversations that have been happening around the amount of need in the system and a lot of progress has been made. It is critical to get the information to legislators in a form that makes sense to them so they have a clear understanding of the issue. Legislators are aware that counties are anxious to know what funds they have to work with and how they can build their budgets. There are still questions being asked as to whether equalization as it is envisioned will really put the money where it is needed. There is recognition of the deficit, but some doubt about whether equalization is going to address it.

Budget Targets – Budget targets came out yesterday. The House is at \$6.4 billion, the Governor is at \$6.5 billion, and the Senate is at \$6.9 billion, so there is a very large range and a lot of tough decisions that will have to be made. The range is close to \$500 million. Those targets will drive all the budget conversations at the state level, not just those on mental health and disability. There is money in each of the plans for mental health and disability services; the question is how that comes together with the considerable amount of money that is needed in Medicaid. The Governor's budget included a sizeable increase in Medicaid. Decisions will have to be made on equalization and the shortfall for sustainability. The legislature as a whole recognizes that spending for current services in fiscal year 2014 does not have enough revenue to support it.

Jack Willey noted that last month during the public comments, Bob Bacon suggested that the Commission might want to follow up with legislators regarding some of the key issues that we felt needed to be addressed. Jack said he considered some additional information that Bob provided, but thought it might be wise to watch what is happening a little longer before sending another letter off to legislators. He said he believes that legislators have been made aware of the budgetary issues facing counties and that the Commission made clear recommendations to the Governor and Legislature in its annual report in January and in the letter submitted on the transition funding issue. He added that he thinks the general public has been made more aware of the issues and asked if the members of the Commission had any other thoughts on the providing specific information to legislators.

Chris Hoffman said he supports Jack's thinking. Legislators seem to be very aware of the issues and have genuine concern, but are continuing to struggle with how to

address the issues and be careful about spending wisely. He said he was encouraged by the proposal relating to making children eligible for non-Medicaid services because it would help integrate the system. Jack indicated that once the funnel date has passed the Commission may want to take another look at any specific areas where they would like to communicate with lawmakers.

In response to a question from Laurel Phipps, Rick said DHS estimates of a shortfall are \$11 to \$15 million. He said there is a question about what the effect on that number would be if a decision is made that Medicaid will be expanded to cover individuals up to 138% of the FPL (federal poverty level), as the Affordable Care Act allows. That has been a major topic of the legislative session. The Governor is skeptical that the federal government will follow through with its commitment to sustain much of the cost. There are also very strong feelings on the part of some legislators that Medicaid expansion is a critical part of what Iowa needs to do to ensure that people have access to services. DHS was asked to estimate how much money counties could potentially save, which all depends on what assumptions are made. The Department took the information available from the consumer level payment data reported by the counties. It combines both Medicaid and non-Medicaid services, so it was necessary to try to extract the Medicaid data to arrive at the best non-Medicaid numbers available.

Two possible scenarios were reviewed:

1. What if we provided the expanded group with a benefit package that was the same as the State's largest HMO (Health Maintenance Organization) package, which is Wellmark Blue Advantage, and assumed mental health parity?
2. What if we made the expanded group eligible for the current Medicaid Plan?

Based on DHS knowledge and some consultation work was done to determine what services would be covered under each of the plans and what the cost would be. The major differences would be that the HMO plan would not pay for anything that looks like care coordination and would not pay for support services like habilitation; the current State Medicaid Plan would cover those items. The data are not very precise because they were not designed for this purpose, but the best guess is that of \$20 million in those types of services; about \$5 million would be Medicaid eligible. Under the HMO scenario, \$27 to \$29 million dollars in non-Medicaid services that counties are now paying for would be covered; under the Medicaid Plan scenario, \$55 to \$60 million of the services that counties are paying for would be covered. Rick noted that there are a series of Milliman Reports on the costs for expanding Medicaid that are available in the Internet, but these amounts would be cost savings that the counties would not incur. That is another factor in the decision making about Medicaid expansion.

Suzanne Watson commented that she hopes people realize that more money is needed to go beyond the basic core services. Rick said that in other states where there are more state dollars involved in mental health and behavioral health care, the investment of state dollars has weighed heavily in favor of Medicaid expansion. In Iowa, we have a somewhat different situation with a lot of counties dollars involved in mental health services.

A break for lunch was taken at 11:55 a.m.

The meeting resumed at 1:00 p.m.

REVIEW OF CARE COORDINATION PLANS

Rick Shults presented an overview of care coordination plans. Some of the more significant changes anticipated are for adults with SMI (Serious Mental Illness) and children with SED (Serious Emotional Disorder); there will be a review of the use of Targeted Case Management for people with intellectual disabilities (ID), but no structural changes are planned.

There are provisions in the reform act that talk about providing ongoing support for Targeted Case Management, establishing online training, establishing outcomes measures for the effectiveness of case management, and providing case management using an evidence-based practice. The two evidence based practices we have focused most on so far are:

- Assertive Community Treatment (ACT)
- Strength-based case management

There are also factors in the mental health and disability redesign legislation that lead the Department to continue to work on developing and growing case management for people with intellectual disabilities.

For children with SED the strong recommendation from the Children's Workgroup is to use health homes as a platform to deliver care coordination using a systems of care approach. This approach is intended to be effective in bringing children placed out of state back home, and preventing more out of state placements in the future. The DHS December 9, 2011 Report recommended the use of health homes for people with SMI to better coordinate services and as part of a financing strategy. We are now in the process of making the shift to using health homes as the vehicle to provide care coordination for adults with SMI and children with SED.

Rick provided some background on the concept of health homes. Health homes were established in the Affordable Care Act by CMS (Centers for Medicare and Medicaid Services). It establishes an approach of delivering care coordination designed around addressing the needs of people with two or more chronic conditions or a severe and persistent mental illness. They further incentive this approach by saying that for the first two years, 90% federal funding will be provided. A health home is not a building or a place, it is a team approach. The team would provide care coordination for the individual. In addition to the individual, the team would include a care coordinator and array of other professionals such as a doctor, nurse, and/or pharmacist. The health home is expected to have access to an array of professionals, but does not necessarily reflect where the person goes to get services. It uses a whole person approach, to look at the individual's life including clinical and non-clinical supports and services. A health home is a tool that can do everything a Targeted Case Manager can do plus more; it

also provides prevention and health promotion. For a population of people who are dying 25 years earlier than their peers from preventable health conditions, that is a significant component.

Health homes are:

- Intended to provide comprehensive coordination of care
- A tool that provides more flexibility in funding
- Helpful in transitioning people between settings
- Effective in chronic disease management for both physical health and mental health
- A way to access to peer support and family support

Health home are required to:

- Use continuous quality improvement
- Achieve outcomes
- Be able to use the HIE (Health Information Exchange) and HIT (Health Information Technology)

Health homes can use a different payment methodology than TCM requires. TCM must be billed on a fee for service basis in 15 minute increments based on individual claims. In the case of health homes, CMS allows a per-member, per-month payment that covers that person's need for that period of time. It is important to continue the quality care coordination that is happening now and find ways to collaborate and work with current case management, using this new health home tool to provide for an array of coordination. Iowa is in the beginning stages and currently has some pilot projects started. DHS is in the final stages of writing revisions to our State Medicaid Plan to be submitted that will allow the use health homes.

Those are the basic concepts. DHS is proceeding with the assumption that the changes to the State Medicaid Plan will be approved and a phase-in approach can begin July 1 in four or five areas of the state with a handful of health homes, which will then grow across the state with new enrollees. For each person who enrolls, we will look at providing their care coordination through a health home. The details are still being worked out. You may hear that Magellan Health Services is going to be the health home. Magellan is involved as part of a technical procurement process, in other words, it is a way to go out around the state and contract with local care coordination providers. It is important to understand that the actual care coordination services will be provided by agencies at the local level, not by Magellan as an agency. An individual would have a care coordinator and access to an array of professionals, family support, and peer support that can "wrap around" that person.

Rick was asked if other populations would still be receiving regular case management services. He responded that for the time being that is the case, the first populations addressed will be adults with SMI and children with SED. Gary Lippe asked if the health home would have to have or contract for all auxiliary supports needed by an individual. Rick responded that is correct. He said the health home concept is intended

to be broader and more flexible than traditional TCM. Case managers are prohibited from providing any direct services, the health home model is more flexible in meeting the person's needs and if there is some marginal direct service provided, that is not an issue. Rick said Iowa has some health homes beginning to operate for chronic physical conditions and have some pilot projects for mental health. People using a health home could receive services anywhere that is appropriate, whether that is in their home, in a clinic, at a provider agency, or elsewhere.

Rick was asked if current case managers would be candidates for becoming health home coordinators. He responded that he would like to see case managers and all the entities that could provide ancillary services get together at the local level and see what they can work out. CMS has not yet been clear about how this will work for people with intellectual disabilities; so far they have focused on mental health.

Deb Eckerman Slack asked if caseloads will be similar to what they are now; she said she is concerned about maintaining the level of service and making sure people are not falling through the cracks. Rick responded that for people with high intensity needs, including most of those now served, it probably will be similar. It is also expected that the system will be serving more people and many of them will have a much lower level of need for services; for those folks the care coordination should be less time consuming and the caseloads will probably be higher. Rick said he has had conversations with IME Administrator Jennifer Vermeer and they agree that they are committed to provide the same level of care coordination to individuals with severe challenges that is currently being provided.

Suzanne Watson asked if the paperwork aspect will be less intense. Rick responded that it will be, noting that, for example, there will no longer be a need to document what is done in 15 minute increments. Susanne also asked if care coordinators will still be requesting funding through Medicaid and the regions as funding sources. Rick responded that they will have the same connection with the regions they have had with the counties. The issue that this has to do with the person's whole life, where they live, where they work, their social connectedness, and all of those things that the counties have often helped support in one way or another means that the same kind of connection with regions will be necessary.

Rick was asked if there has been any thought given to considering care coordination to be "a step away" from targeted case management and a different level of care. Rick responded that he thinks it is important to address and dispel the idea that the caseload will be much higher because that will not be true for people with a high intensity of need. He said he sees health homes as more as a tool that will provide more flexibility for everyone.

Gary Lippe asked if this is sort of a hybrid system that takes the best of both traditional case management and the system of care approach. Rick responded that there is sometimes confusion about why you would have both a health home and a system of care. He said he sees the health home is the place that provides the care coordination

and systems of care is the method or practice used to provide that care. It is not a duplication of effort; it is a system of care delivered by a health home. Gary Lippe added that a system of care is not one entity; it is more of a community approach.

The pilot projects are:

- Eyerly Ball and Broadlawns in Polk and Warren Counties
- The Abbe Center in Linn County
- Siouxland Mental Health Center in Woodbury County
- Hillcrest Family Services in Dubuque County

Rick noted that there may be some individuals with multiple chronic physical health conditions that are assigned to a health home, but we have mainly been discussing behavioral health homes.

Gary Lippe asked who in a local community would be the logical players to provide health homes; would it be community mental health centers (CMHCs), child health specialty clinics (CHSCs)? And who would they reach out to in order to provide the all components they need? Rick responded that it would likely be entities such as CMHCs and CHSCs. He also noted that there are some outside experts on these kinds of questions that would be very well equipped to advise. The National Council on Behavioral Health is very focused on quality services and helps behavioral health providers, including care coordinators, link with all these changes as they are happening. There are also resources available on the Internet that have good information on how to collaborate at the local level, including Dale Jarvis and Associates, and David Lloyd and his group, MTM Services. They offer ideas on how to collaborate and use the skills and expertise available to move to the next paradigm. This is one of the next big things that are going to happen and part of the future of health care delivery. You will also be hearing about Accountable Care Organizations (ACOs), which is an even larger paradigm. Care coordination is the next HMO; we all have to learn how to live in this new health care environment collaboratively.

In response to a question, Rick said that Magellan will be a key partner, but they will be looking for willing partners to deliver quality services. There should be a lot more flexibility and the most important factor will be the outcomes that show how well the individuals being served are doing.

OFFICE OF CONSUMER AFFAIRS UPDATE

Todd Lange, Director of the Office of Consumer Affairs, gave a brief overview of the OCA and the work they do. This version of the OCA started about two years ago. Todd is the statewide director and works with five regional coordinators around the state. The five regions are coordinated based on the DHS service areas. The regional coordinators are:

- Region 1: Braden Daniels from Council Bluffs (Region 1 is 30 Western Iowa counties)
- Region 2: Jim Paprocki from Waterloo (Region 2 is 27 NE Iowa counties)

- Region 3: Todd Noack from DeWitt (Region 3 is 10 SE Iowa (mostly border counties))
- Region 4: Ann Wood from Cedar Rapids (Region 4 is 17 SE counties)
- Region 5: Jessica Tull from Ames (Region 5 is 15 South central Iowa counties)

Each of the regions has an advisory committee with 5 to 7 members from a variety of backgrounds. They are individuals with lived experience, family members, and providers. They hold bi-monthly meetings that are open to the public. They also get out and talk to people in their regions to provide updates and get feedback so they understand local issues and opportunities. Todd said he tries to be involved in the local regions as much as possible and stays involved at the state level by attending Mental Health Planning Council, MHDS Commission, and Olmstead Consumer Task Force meetings to keep informed and share that information. He said he would be glad to provide additional information on OCA to the Commission.

Todd noted that DHS has worked hard to keep the channels of communication open. They host meetings for advocacy group representatives almost monthly to provide updates and listen to concerns. Rick Shults and Chuck Palmer have gone out to communities around the state to participate in local forums and bring information to the communities that helps keep everyone informed about the progress of mental health and disability redesign. He noted that Rick will be attending a forum in Dubuque on Saturday.

Todd said that the idea of peer support and family support services is very important to the OCA. They have found a strong desire for peer support services and for more training to spread peer support across the state. They have also received a lot of positive feedback from people about how peer support has improved their lives. He said they also work to dispel rumors and ease concerns and have been doing their best to assure people that there will still be a CPC or similar local person available in the community to assist people as Iowa moves from a county to a regionally administered system.

Braden Daniels from Region 1 and Jessica Tull from Region 5 were unable to join the meeting today.

Jim Paprocki from Region 2 said one of the main things he has been hearing in the northeast Iowa counties is concern about the availability of services. There does not seem to be the community capacity in many rural areas to provide the services people are seeking. In the Decorah area and surrounding counties transportation is a significant issue. The state has a contract with a private provider to deliver non-emergency medical transportation, but it is not meeting the needs of a lot of people in the area; he said he has been working to identify the issues that can be resolved and wants to be supportive of efforts to improve the service.

Jim noted that Community Social Services is a 22-county region that has been functioning as a regional entity for some time. It includes 20 of the counties in his

regional area. Representatives from the counties in the area have been invited to participate on the advisory committee. There is a person from the CSS group that attends the meetings.

Jim said the primary issues he has heard concerns about are:

- The availability of services in general
- The availability of peer support
- Problems with non-emergency medical transportation
- The desire to have access to recovery centers where people can go to interact and access peer support

Chris Hoffman encouraged Jim to contact him and talk about coordinating efforts.

Todd Noack from Region 3 said he has spent time introducing himself to providers, advocates, CPC, agencies, and others in the community and has been met with an open response in most cases. He said that he and other OCA coordinators recently hosted community conversations with ID Action in the communities of Washington and Clinton. OCA tries to partner with other organizations; he worked with the MJL Foundation on a suicide prevention walk in DeWitt, where OCA had a table to hand out resources and let people know what they do. OCA has worked with Grandparents and Others in Clinton; they are a group representing grandparents who have adopted or are raising their grandchildren.

Transportation is a huge issue in Region 3. The individual making the appointment has to rely on the health care provider to complete paperwork that is faxed to them, fax it back to the transportation provider, make sure the arrangements are made and that the ride shows up on time. There are a lot of things that can go wrong in that process, including arriving 10 or 15 minutes late for an appointment and getting turned away. People who are on IowaCare and not Medicaid can only go to the University of Iowa for treatment, which creates other complications.

Todd said he has reached out to groups including Big Brothers, Big Sisters, Community Action, and others is working to coordinate with many groups in the community, including volunteering at a new homeless center on the first night it opened. He said there are a lot of people worried about the uncertainties surrounding redesign and he has been trying to keep them positive and help them understand that things will change, but the intent is to make them better, not to take away services that are available now. OCA has a website and Facebook page where people can go for more information.

Ann Wood from Region 4 said that when she visits people in the community she tries to deescalate fears that arise out of rumors or news reports. She said she feels it is important to keep consumers updated on what is going on in a positive way and to try to help the consumer understand that this is a process and it will take some time to work things out, but will get better. She said she has been able to talk to patients in hospital psychiatric units about the positive opportunities and resources available to them and

help them to see that there is a life outside when they leave the hospital and there are many ways to seek support.

Ann said she has been working with a group in Johnson County that is trying to start up a wellness center; they have established a board and are looking for facilities. Ann serves on the board of NAMI (National Alliance on Mental Illness) and the board of USPRA (United States Psychiatric Rehabilitation Association). She said NAMI will be sponsoring an ID Action forum in March; local legislators and the county CPC have been invited to answer consumer questions about how they will be affected by redesign changes. She said people are concerned about how they will be effected by the changes they hear about connected with redesign and need to understand what is happening.

Ann says she has heard concerns about people having to travel to the other side of the state for an inpatient psychiatric bed, which leaves them without their local supports, and even some reports of people being denied admission because there are no beds available and not offered other options. She said the Abbe Center started a new “easy access” program less than a month ago, which works like urgent care for mental health needs and makes services more readily available. That program has really helped in Linn County. In other counties, there is sometimes a wait of several months to see a psychiatrist.

Ann said transportation services have been cut, which makes it very difficult for people to get to appointments, especially in rural areas. There have been many complaints about the non-emergency medical transportation system. Some consumers have reported that they have quit trying to use the service because they have had bad experiences with it.

Other concerns include:

- The number of funded visits to psychiatrists and therapists has been reduced.
- Waiting lists have been instituted for some services.
- There is a lack of peer support services and a desire for more availability of peer support training.
- People who are dually eligible are concerned about being able to continue accessing the providers of their choice.
- The discontinuation of IowaCare and what will happen to those individuals who have been using it if Medicaid Expansion does not occur
- Psychiatric rehabilitation is not included as a core service, yet it offers the opportunity for people to go back to work

Ann said that being a regional coordinator is a privilege and it has been a good experience to work with Todd and the other coordinators.

Todd Lange said he and other regional coordinators would be happy to give periodic updates to the Commission.

NEXT MEETING

- The next meeting is scheduled for Thursday, March 21, 2013 at the Pleasant Hill Public Library
- Laura Larkin will talk about the Children's Mental Health Report
- Legislative update
- The CSS Plan will be represented for vote
- Discussion of core and core plus services review for committee

PUBLIC COMMENT

Suzanne Watson asked how health homes relate to people who are dual eligible for Medicare and Medicaid. It was noted that CMS is very interested in engaging states in using health homes for their dual eligible population. Rick noted that could be an interesting discussion for another meeting.

Rick Shults briefly addressed the concern shared by Ann Wood about people who are dually eligible being concerned that they will not be able to continue accessing their current providers of choice, clarifying that they can keep their current physicians.

Ann also asked if there is any thought or possibility to extend the age of the MEPD program beyond age 65, since so many people are working past that age, but having their Medicaid services cut. Rick responded that he will do some research and bring that issue back at the next meeting.

The meeting was adjourned at 2:30 p.m.

Minutes respectfully submitted by Connie B. Fanselow.